
Medicare Learning Network
PAYMENT SYSTEM FACT SHEET SERIES
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
Inpatient Psychiatric Facility Prospective Payment System
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Effective January 2005, §124 of Public Law 106-113, the Balanced Budget Refinement Act of 1999, required implementation of the **Inpatient Psychiatric Facility Prospective Payment System (IPF PPS)** for psychiatric services furnished to Medicare patients in psychiatric hospitals and distinct part units in acute care hospitals and Critical Access Hospitals.

The following requirements must be met in order for payment to be made for inpatient psychiatric hospital services:

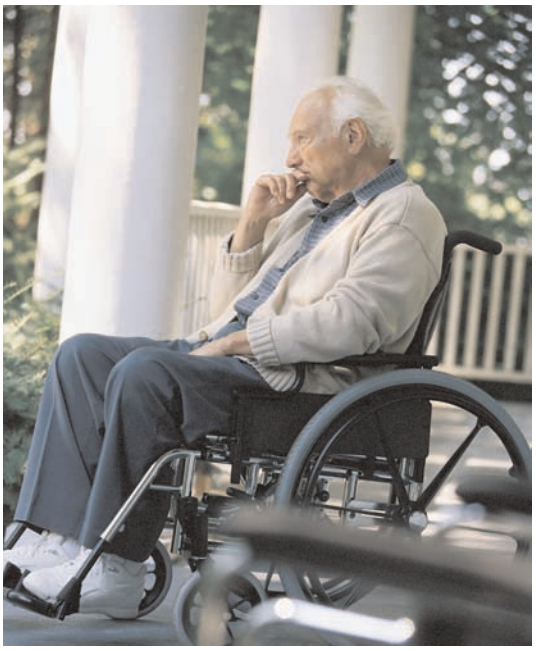
- The patient must be furnished active treat ment that can reasonably be expected to improve his or her condition;
- Services must be furnished while the patient is receiving either active treatment or admission and related services necessary for diagnostic treatment;
- A physician must provide certification at the time of admission or as soon thereafter as is reasonable and practicable that the patient needs, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel; and
- A physician must provide the first re-certification as of the 12th day of hospitalization and subsequent re-certifications at intervals established by the utilization review committee (on a case-by-case basis, if it so chooses), but no less than every 30 days that the patient continues to need, on a daily basis, active inpatient treatment furnished directly by or requiring the supervision of IPF personnel.

Patients who are treated for psychiatric conditions in specialty facilities are covered for 90 days of care per illness with a 60-day lifetime reserve and for 190 days of care in freestanding psychiatric hospitals.

HOW PAYMENT RATES ARE SET

Under the IPF PPS, Federal per diem rates include inpatient operating and capital-related costs (including routine and ancillary services) and are determined based on:

- Geographic factors
  - A hospital wage index value is assigned to account for geographic differences in wage levels
  - The non-labor related portion accounts for higher cost of living for IPFs located in Alaska and Hawaii;
- Patient characteristics
  - Diagnosis Related Group (DRG) classification
  - Age
  - Presence of specified comorbidities
  - Length of stay; and
- Facility characteristics
  - A 17 percent payment adjustment for rural facilities due to their higher costs
  - Teaching hospitals receive payment to account for indirect medical education costs.



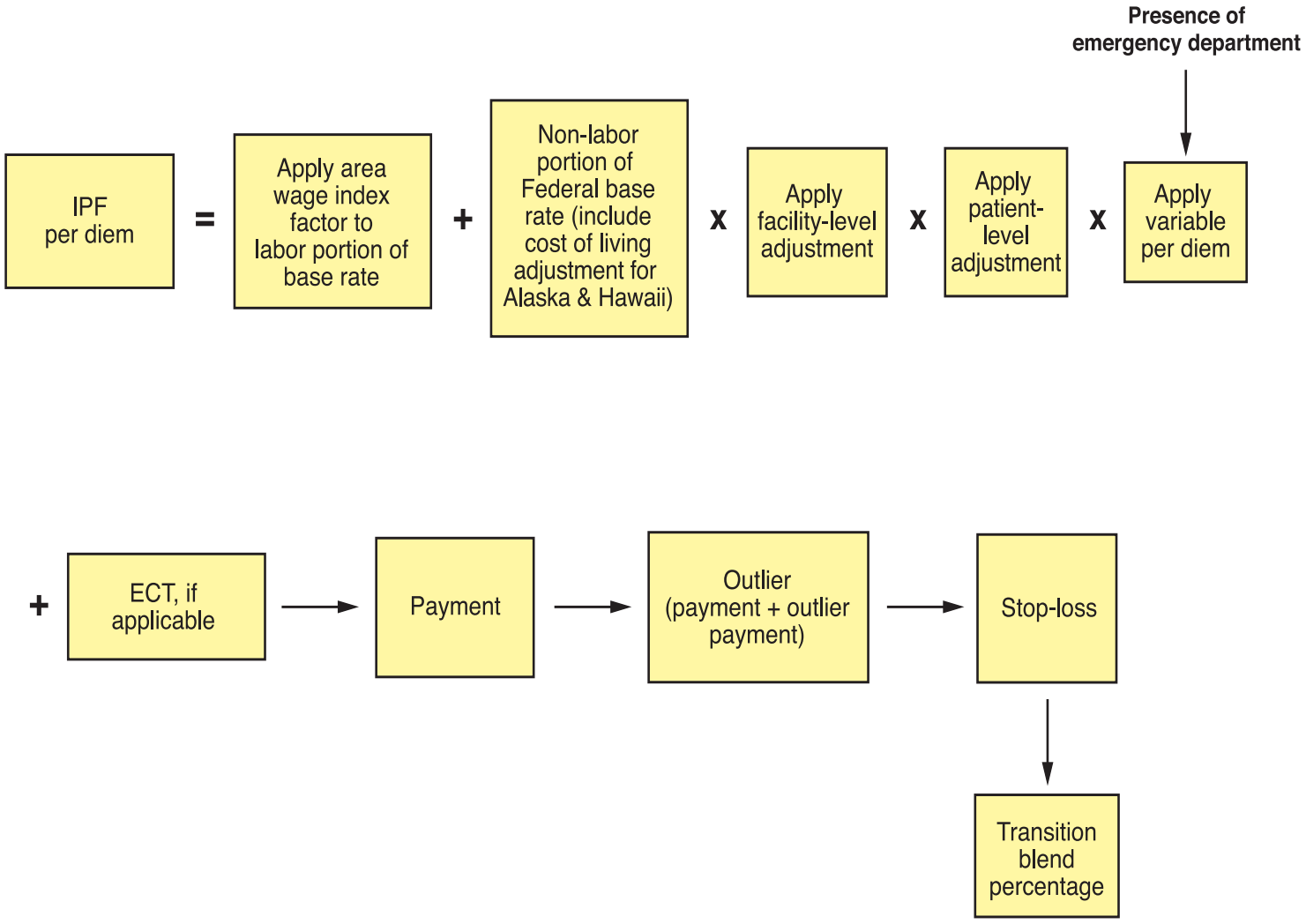
Additional payments are provided for the following:

- Patients treated in IPFs that have a qualifying emergency department receive a 12 percent higher payment for the first day of the stay;
- The number of Electroconvulsive Therapy (ECT) treatments furnished; and
- Outlier payments for cases that have extraordinarily high costs (payment is for 80 percent of the costs above the threshold plus the estimated rate for days 1 through 8 and 60 percent of excess costs for the remaining days).

The per diem base rate excludes pass-through costs such as bad debts and graduate medical education.

IPFs are paid under the PPS according to their cost reporting year and transition into the PPS. The transition to 100 percent PPS rates will be complete for cost reporting periods beginning in 2008. During the transition, IPFs will not be paid less than 70 percent of what they would have been paid under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Under TEFRA, IPFs were paid on the basis of their average costs per discharge, not to exceed the facility-specific limit.

Inpatient Psychiatric Facility Prospective Payment System



RATE YEAR 2007 UPDATE

The Rate Year 2007 update to the IPF PPS, which applies to IPF discharges that occur during the period July 1, 2006 through June 30, 2007, includes the following changes:

- Market basket update
  - The new Rehabilitation/Psychiatric/ Long-Term Care market basket is now being used to update the Federal per diem base rate
  - Effective for cost report periods beginning on or after October of each year, a re-based, 2002-excluded hospital market basket is used to update the cost-based portion (TEFRA);
- Pricer updates
  - Federal per diem base rate: $595.09
  - Fixed-dollar loss threshold amount: $6,200
  - Revised standardization factor: 82.54 percent
  - Transition blend for cost reporting periods beginning on or after January 1, 2006 but before January 1, 2007: 50 percent PPS and 50 percent TEFRA
  - Transition blend for cost reporting periods beginning on or after January 1, 2007 but before January 1, 2008: 75 percent PPS and 25 percent TEFRA
  - Core-Based Statistical Area (CBSA) designations will be used to assign a wage index value for discharges occurring on or after July 1, 2006, with no separate transition blend for conversion to the CBSA-based labor market areas
  - Labor-related share (75.665 percent): $450.27
  - Non-labor related share (24.335 percent): $144.82
  - ECT rate: $256.20;
- DRG and comorbidity adjustments; and
- National cost to charge ratios (CCR) which apply to IPFs that have not yet submitted their first cost report, whose operating or capital CCR is in excess of three standard deviations above the corresponding national geometric mean (the ceiling), or whose Fiscal Intermediaries obtain inaccurate or incomplete data with which to calculate either an operating or capital CCR or both

  - Urban
    - Median: 0.55
    - Ceiling: 1.7179
  - Rural
    - Median: 0.71
    - Ceiling: 1.7447.

To find additional information about the IPF PPS, visit **www.cms.hhs.gov/InpatientPsychFacilPPS** and the ***Medicare Benefit Policy Manual*** (Pub. 100-02) located at **www.cms.hhs.gov/Manuals/IOM/list.asp** on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare Contracting Reform (MCR) Update
Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 enacted numerous contracting reforms. A key aspect of these reforms is that Medicare will begin integrating Fiscal Intermediaries (FI) and Carriers into a new single authority, called a Medicare Administrative Contractor (MAC). As of October 1, 2005, new Medicare Contractors are called MACs. Also, from October 2004 through October 2011, all existing FI and Carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at **www.cms.hhs.gov/MedicareContractingReform** on the CMS website.

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